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No. 89-1419

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

HALIFAX HOSPITAL MEDICAL CENTER,
Petitioner,

v.

RICHARD A. BOLT and
RICHARD A. BOLT, M.D., P.A.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether a hospital and its medical staff conspire for purposes of the Sherman Act when the medical staff makes a credentialing recommendation to the governing board that the board accepts.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

This brief is filed on behalf of the American Hospital Association in support of Petitioner, Halifax Hospital Medical Center (Halifax). Consent from counsel for all parties has been filed with the Clerk of this Court.

INTEREST OF THE AMICUS CURIAE

The American Hospital Association (AHA) is the primary organization of hospitals in the United States, including in its membership approximately 5,500 hospitals and other health care institutions, and nearly 48,000 individual members. In the increasingly complex environment in which hospitals today operate, the AHA has striven to assist its members to achieve the delivery of quality health care to

the communities that they serve. Nothing is more important to this effort than the implementation of reliable and well-administered systems to assure proper physician "credentialing".[1] Without the ability to assure quality physicians, hospitals would fail in their central mission to patients.

Antitrust analysis of the critical relationship between hospitals and physicians, as it pertains to the evaluation of physicians in state-mandated peer review programs and to other credentialing decisions, must proceed based on an accurate appreciation of the economic interests involved. Such an analysis will show that, for these purposes, the hospitals and their medical staffs operate as a single economic entity. By misunderstanding that relationship, the court below has thrown into doubt literally thousands of peer review programs nationally. In addition, it has placed every hospital in the country in the position of a potential antitrust defendant for every medical credentialing decision that is made. This will impede the AHA's members' ability to obtain the needed input of physicians in staffing decisions. Consequently, unless this Court grants the petition and reverses the decision below, the public's receipt of quality medical care will be adversely affected.[2]

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[1] As used herein, "credentialing" means the process by which the hospital medical staff recommends and the hospital board decides to appoint medical staff members and to award privileges that permit the practitioner to provide medical or other patient care services in the hospital, within well-defined limits. *See, e.g.* Joint Commission on Accreditation of Health Care Organizations, *1990 Accreditation Manual for Hospitals* at 95-117 (1989).

[2] The AHA's brief will address only the second question presented by Halifax in the petition.

STATEMENT OF THE CASE

The AHA adopts the Petitioner's statement of the case, and adds the following points.

First, Dr. Richard A. Bolt alleged several different possible conspiracies in his complaint. Complaint, ¶ 19; *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810, 818 (11th Cir. 1990). The one relevant to the AHA's brief is the conspiracy between Halifax and two members of its medical staff, Dr. Shedrick H. Roberson, a proctologist, and Dr. Alvin E. Smith, an oncologist. Dr. Smith is Chief of Staff at Halifax and served on Halifax's Credentials and Executive Committees. *Id.* at 816. Dr. Roberson is Chairman of the Department of Surgery and served on Halifax's Executive Committee. These physicians, by virtue of their positions, were required under the hospital's bylaws to participate in the credentialing process. Each "played some official role in the privileges decision" challenged by Dr. Bolt. *Id.* at 816. They are accused of conspiring to include language critical of Dr. Bolt within a staff Judicial Review Committee report utilized in the hospital's determination to exclude Dr. Bolt.[3]

Second, the procedures employed by Halifax in connection with its review of staff physician performance were extensive. Each new physician is given a probationary staff appointment lasting for one year, which is renewable for an additional year. At the end of the second year, the physician may apply for active staff membership. In connection with

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[3] The Eleventh Circuit also considered allegations of conspiracy among other hospitals and members of medical staffs, and a community-wide conspiracy. The parties to those claims included Daytona Community Hospital, Ormond Beach Memorial Hospital, Dr. Boye (an internist), Dr. Marino (an anesthesiologist), Dr. Stose (an orthopaedic surgeon) and the Volusia County Medical Society.

that application, the hospital appoints a Credentials Committee, composed of active staff members. The Credentials Committee's recommendation is reviewed by an Executive Committee, also composed of active hospital staff members. If the Executive Committee's recommendation is negative, the physician may appeal to a Judicial Review Committee, also comprised of active staff members. The final responsibility for appointments rests with the hospital's governing Board of Commissioners.

These procedures were followed in Dr. Bolt's case at Halifax. The Executive Committee prepared a careful statement of the basis for its action recommending that Dr. Bolt be denied reappointment. The Judicial Review Committee found no reason to disagree with the Executive Committee's recommendation, and the Board of Commissioners ultimately decided not to reappoint him. *Id.* at 815.

REASONS FOR GRANTING THE PETITION

I. Importance of Granting the Petition

Compelling reasons exist to grant this writ, and to hear this case now. Not only does the Eleventh Circuit's opinion openly conflict with the Third Circuit's decision in *Weiss* v. *York Hospital*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985),[4] but the decision below treats the question of antitrust conspiracy in a way that fundamentally misunderstands this Court's decision in *Copperweld Corp.* v. *Independence Tube Corp.*, 467 U.S. 752 (1984). Further-

[4] The court below, recognizing the conflict, characterized as "faulty" the Third Circuit's decision in *Weiss:* "Relying on the rule that a corporation cannot conspire with its officers and directors, . . . some courts have held that a hospital cannot conspire with its medical staff for purposes of Section 1 liability. . . . We find this analogy faulty, however". 891 F.2d at 819.

more, it presents "an important question of federal law which has not been, but should be, settled by this Court." Supreme Court Rule 10.1(c).

The antitrust implications of the collaboration between hospitals and their medical staffs have been the subject of confusion in the lower courts for some time.[5] Until this Court addresses the problem, hospitals and ultimately the American public will pay the price of excessive expenditures on litigation at a time when hospitals are endeavoring to use their resources more efficiently.

Furthermore, if the decision below stands and physicians playing "some official role in the privilege decision" (*Bolt*, 891 F.2d. at 816) and the hospital board making the decision can "conspire", then theoretically, a "conspiracy" would occur every time the medical staff made a credentialing recommendation that the board accepted (*see infra* pp. 11-13, 16-17). Thus, a unilateral hospital privileging deci-

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[5] In addition to the conflicting decisions in *Weiss*, *supra* note 4, and the court below, *see, e.g.*, Nanavati v. Burdette Tomlin Memorial Hospital, 857 F.2d 96, 118 (3d Cir. 1988), *cert. denied* 109 S.Ct. 1528 (1989) (following *Weiss*); Potters Medical Center v. City Hospital Ass'n, 800 F.2d 568, 573 (6th Cir. 1986) (no conspiracy possible); Oltz v. St. Peter's Community Hospital, 861 F.2d 1440, 1450 (9th Cir. 1988) (finding *Bolt* "persuasive"); St. Joseph's Hospital, Inc. v. Hospital Corporation of America, 795 F.2d 948 (11th Cir. 1986) (suggesting that general *Copperweld* rule does apply to hospital-medical staff arrangements, unless staff has independent personal stake); Smith v. Underwood Memorial Hospital, 1987-1 Trade Cas. (CCH) ¶ 67,538 (D.N.J. 1987); Friedman v. Delaware County Memorial Hospital, 672 F. Supp. 171 (E.D. Pa. 1987); McMorris v. Williamsport Hospital, 597 F. Supp. 899 (M.D. Pa. 1984). Dr. Bolt himself asked the court below for "clarification of the law in this difficult area . . ." Supplemental Brief of Dr. Bolt, April 7, 1988 at 45.

sion would be bootstrapped into a conspiracy. This would punish the coordinated conduct of the board and the medical staff and would discourage the hospital from creating a division of labor whereby the medical staff, on behalf of the hospital, reviews membership applications and makes recommendations to the governing board for its decision (*see infra* pp 11-13, 16-17 and *Weiss, supra* (adopting the reasoning that the medical staff in credentialing matters acts on behalf of the hospital.)) Such coordination has presumed benefits and the loss of these benefits, as *Copperweld* recognizes, would deprive patients of efficiencies that decentralized management brings.

Certainly, in the credentialing process, hospital boards must have the benefit of medical staff recommendations based on the staff's peer review of applicants for staff membership. If that communication is punished and therefore discouraged, the utility of the staff's peer review is diminished. The quality of medical care in the United States depends, as the Seventh Circuit recognized in *Marrese v. Interqual, Inc.*, 748 F.2d 373, 392 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985) on *effective* peer review.

Thus, not one but several of the considerations regarded as "special and important" reasons for granting a writ of certiorari in Rule 10 of this Court's 1990 Rules are present here.[6] These reasons are in no way undercut by Congress's passage of the Health Care Quality Improvement Act of 1986.[7] That statute confers a limited antitrust immunity on physicians and other persons who participate in

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[6] Specifically, this case meets the criteria of Rule 10.1(a), clause 1, and Rule 10.1(c) both clauses. Rules of the Supreme Court, January 1, 1990.

[7] 42 U.S.C. § 11101 et seq. Because Dr. Bolt's case arose before the passage of the Act, it does not apply here.

professional review activities by exempting them from treble damages liability in private suits if the professional review action meets the standards set forth in the statute.[8] However, the prerequisites for immunity are strict enough that the law may not adequately stem the flood of staff privileges litigation.[9] Furthermore, hospital governing boards frequently communicate with medical staff members on legitimate matters not falling within the scope of the Act's immunity provisions.[10] Therefore, the issue presented in this

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[8] 42 U.S.C. §§ 11111(a), 11112(a).

[9] For example, the Act requires that the action must be taken based on a reasonable belief that it was warranted by the facts known. 42 U.S.C. § 11111(a)(4). A disgruntled physician need only allege that no such reasonable belief existed in order to commence a legal action, and perhaps even to survive a defense motion for summary judgment. Immunity is also contingent on the provision of information that is not false, for persons providing information to review bodies. 42 U.S.C. § 11111(a)(2). For a hospital, the practical operation of the Act places the burden on the hospital and the physician defendants to establish that a peer-review decision was based on the physician's competence. *See* 42 U.S.C. § 11151(9) (Supp. 1988); Blumenstein and Sloan, "Antitrust and Hospital Peer Review," 51 Law & Contemp. Prob. 7, 83 n.598 (1988). Indeed, Congress realized when it passed the Act that the reporting system created by the legislation would result in an increase in antitrust litigation. See H.R. Rep. No. 99-903, 99th Cong., 2d Sess. at 3, *reprinted in* 1986 U.S. Code Cong. & Admin. News at 6287. It chose to confer only a limited immunity in response to that problem.

[10] There is no immunity, for example, for peer review activity unrelated to physician competence. 42 U.S.C. § 11151(9)(E) (Supp. 1988). Thus, a medical staff recommendation and hospital board decision to terminate a hospital service, resulting in the termination of a physician's permission to practice, is not covered.

case will continue to be important to hospitals even after the pre-1986 Act cases have all been resolved.

Finally, although the Eleventh Circuit remanded Dr. Bolt's case to the district court for further proceedings, those proceedings will have no bearing on the questions presented here and now. The evidence called for by the Eleventh Circuit on remand has to do with particular proof of the specific elements of a conspiracy, namely: did Dr. Bolt offer evidence tending to exclude the possibility of independent action on the part of the hospital and on the part of the medical staff members? This evidence is irrelevant if the hospital and its staff are properly regarded as one economic unit in the context of peer review. The lower court conceded, correctly, that:

> [t]he directed verdicts in this case would therefore have been proper if, as the defendants contend, the DCH defendants were legally incapable of concerted action within the meaning of Section 1 of the Sherman Act.[11]

Therefore, the Eleventh Circuit itself recognized the central importance of the conspiracy conclusion. This issue is important to the effective functioning of hospitals, and it is ripe for consideration now.

II. This Court's *Copperweld* Decision and Sound Economic Analysis Require a Reversal of the Decision Below

The lower court made two mistakes. First, it ignored *Copperweld* by basing its conclusion that a conspiracy was possible between a hospital and its medical staff on considerations of formal legal status, rather than on economic realities. Second, it fundamentally misunderstood hospital

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[11] 891 F.2d at 818-19.

organization and failed properly to analyze the economic relationship between the governing board and medical staff members.

A. *Copperweld* Establishes a Functional Economic Test for Determining Plurality of Actors Under Section 1.

The requirement of a combination or conspiracy lies at the heart of section 1 of the Sherman Act. This Court has taken pains in recent years to clarify its precise scope, and thereby to ensure that the antitrust laws are invoked only against genuinely anticompetitive arrangements and that they are not used to stifle legitimate business practices. For example, in *Monsanto Co.* v. *Spray-Rite Service Corp.*, 465 U.S. 752 (1984), in an effort to protect bona fide communications between manufacturers and distributors, the Court held that a conspiracy could be inferred only from "evidence that tends to exclude the possibility of independent action by the manufacturer and distributor." *Id.* at 768. Similarly, guarding against an implausible inference of conspiracy, the Court held in *Matsushita Electric Industrial Co.* v. *Zenith Radio Corp.*, 475 U.S. 574, 588 (1986) that an inference of conspiracy must be reasonable in light of the competing inferences of independent action or collusive action that could not have harmed the plaintiffs. Finally, in *Copperweld*, this Court concluded that a parent corporation is not legally capable of conspiring with its wholly owned subsidiary. 467 U.S. at 752. Those two entities have a "complete unity of interest," pursuant to which the subsidiary must and does act solely for the benefit of the parent.

The court below concluded that the hospital and members of its medical staff were legally capable of concerted action because they were, in the court's view, "legally separate entities." *Bolt*, 891 F.2d at 819. This conclusion ignores the central point of *Copperweld*. Formal legal sepa-

rateness, even where it exists, does *not* suffice to show that two entities can conspire for purposes of the Sherman Act.[12]

The business world is filled with examples of formally separate "persons" whose concerted activity was never meant to be judged under Sherman Act § 1. As the Court pointed out in *Copperweld*, officers and employees of the same firm are surely separate individuals, in law and in fact, but "it is perfectly plain that an internal 'agreement' to implement a single, unitary firm's policies does not raise the antitrust dangers that § 1 was designed to police." 467 U.S. at 769. Similarly, the internally coordinated conduct between a corporation and one of its unincorporated divisions must be understood as unilateral for § 1 purposes. Finally, the direct holding of *Copperweld* was that a parent corporation could not conspire with one of its wholly owned subsidiaries.

The key to ascertaining whether or not the necessary plurality of actors exists lies in whether or not the economic resources that they control are independent. As the Court put it in *Copperweld*, where previously independent interests engage in a "sudden joining of economic resources," a combination or conspiracy for purposes of section 1 is legally possible. On the other hand, where there is a continuation of the same organization of resources, the activities in question are unilateral. Thus, a parent and a subsidiary represent two aspects of the same economic resources, and the establishment of a particular "agreement" between them does not aggregate previously independent sources of economic power. Similarly, where a hospital and medical staff are engaged in the credentialing process, there is no joining of independent economic resources. Instead, it reflects no more

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[12] The medical staff is not, in any event, a legal entity. *See infra* pages 11-13.

than the hospital's division of labor and an acknowledgement that the hospital's sole resource for assessing the quality of its medical services resides within its medical staff.

B. The Medical Staff Acts for and on Behalf of the Hospital in Fulfilling the Hospital's Exclusive Responsibility for Credentialing.

Both as a matter of economic interest and pursuant to applicable state laws, the medical staff acts as an integral part of the hospital's management.[13] "[T]he staff must be held strictly accountable to the governing board for its control of quality. A hospital, therefore, does not consist of two organizations — business administration and medical. Rather, a hospital is a single organization; the medical activities cannot be separated from the business side." Southwick, *The Law of Hospital and Health Care Administration* at 428 (1978).

The American Hospital Association's Guidelines on the Role and Functions of the Hospital Medical Staff state explicitly that:

> [t]he medical staff, working through the hospital medical staff organization, has primary responsibility for developing a governance mechanism that is approved by the governing board and for organizing the medical staff as a body accountable to

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[13] *See, e.g.*, American Medical Association/American Hospital Association, Report of the Joint Task Force on Hospital-Medical Staff Relationships at 9, 11 (Feb. 1985); Office of the General Counsel of the American Hospital Association, Legal Status of Medical Staff (May 1986) (compendium of statutes and regulations of the 50 states and the District of Columbia regarding the responsibilities, roles, and relationship of the hospital, its governing board, and the organized medical staff).

> the governing board for the quality of medical care provided in the institution.[14]

The laws governing Halifax were consistent with these guidelines. Florida law provides that the hospital organization shall have an effective governing authority responsible for the legal and moral conduct of the hospital as a functioning institution. Pursuant to this obligation, the governing body must provide for the appointment, reappointment or dismissal of members of the medical staff. As an integral part of that appointment process, the board seeks the medical staff's "recommendation." Fla. Admin. Code § 10D-28.56 (1979).

Under Florida law, the process for credentialing physicians must comply with the standards outlined by the Joint Commission on Accreditation of Hospitals and the Principles of Participation in the Federal Health Insurance Program for the Aged. Fla. Stat. § 395.065(1) (1979). The 1981 standards, which governed the credentialing process at issue here, provided:

> The governing body shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for clinical privileges. Such delegation, however, does not relieve the governing body of its responsibility for appointing members of the medical staff.

Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals*, Standard IX, Governing Body, 1981 Ed.

Thus, in the context of credentialing, the role of the medical staff is purely advisory. It has no power to imple-

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[14] American Hospital Association Guidelines, approved by the American Hospital Association General Counsel on April 15-16, 1981, revised April 16, 1986.

ment decisions on its own. No matter how much the credentials committees, executive committees, and judicial review committees say or do with respect to a particular application, only the hospital's board of trustees may make the final decision. In this kind of case, where the coordination "does not create additional market power or facilitate a restraint," and where "one of the alleged co-conspirators has complete control over the situation and can fully implement the alleged restraint without regard to what the other conspirator desires or does," conspiracy analysis makes no sense.[15]

C. The *Weiss* Decision Correctly Applies *Copperweld.*

The facts of the Third Circuit's decision in *Weiss* illustrate the line between unilateral and concerted action nicely in the context of hospital organization. Briefly stated, in *Weiss*, an osteopathic physician (D.O.) sued York Hospital and members of its medical staff for conspiring to deny him staff privileges there. York Hospital for many years had corporate charter and bylaw provisions barring D.O.'s from obtaining privileges, and its medical staff had continued to be exclusively allopathic physicians (M.D.'s). The plaintiff alleged that York applied a discriminatorily high standard for the medical qualifications of D.O.'s, and for those few who passed the test, it conferred only the lowest category of staff privileges.

In a part of the opinion not directly relevant here, the Third Circuit found that the medical staff was a combination of individual doctors who were capable of conspiring

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[15] P. Areeda, Antitrust Analysis ¶ 14.62b, at 222-23 (1986). Professor Areeda argues that conspiracy is an "inapt description of consultation and direction," when one of the parties lacks the legal power to disobey. *Id.* ¶ 14.62c, at 223-24.

among themselves against the plaintiff. As in other cases raising questions of exclusion of an entire class of health care provider, this conclusion apparently rests on the broad economic competition that M.D.'s face from alternative providers.[16] However, the court squarely held that "the hospital cannot legally conspire with its medical staff."[17] It explained why not as follows:

> The medical staff was empowered to make staff privilege decisions *on behalf* of the hospital. As such, with regard to these decisions, the medical staff operated as an officer of a corporation would in relation to the corporation. Although the members of the medical staff had independent economic interests in competition with each other, the staff as an entity had no interest in competition with the hospital. 745 F.2d at 817 (emphasis added).

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[16] *See, e.g.*, Oltz v. St. Peter's Community Hospital, 861 F.2d 1440 (9th Cir. 1988) (conspiracy between anesthesiologists and hospital to exclude nurse anesthetists), Cooper v. Forsyth County Hosp. Authority, Inc., 789 F.2d 278 (4th Cir. 1986), *cert. denied* 479 U.S. 972 (1986) (alleged conspiracy by hospital and orthopaedic surgeons directed against podiatrists; failed for lack of evidence). *Cf.* Wilk v. American Medical Ass'n, 895 F.2d 352, (7th Cir. 1990).

[17] 745 F.2d at 815, 817. The Third Circuit's later opinion in Miller v. Indiana Hospital, 843 F.2d 139, 144 (3d Cir.), *cert. denied* 109 S.Ct. 178 (1988), did not change this part of the holding, for the simple reason that in *Miller*, the court did not understand "the hospital at this stage of the proceeding to be challenging either the elements of conspiracy or the interstate commerce effect of its actions." The court reaffirmed *Weiss* in Nanavati v. Burdette Tomlin Memorial Hospital, 857 F.2d 96, 118 (3d Cir. 1988), *cert. denied*, 109 S.Ct. 1528 (1989).

The *Weiss* court therefore concluded, consistently with *Copperweld*, that no conspiracy was possible between the hospital and its medical staff. The staff members were not competitors of the hospital, and the combination of the staff and the hospital was not an aggregation of previously independent economic forces.

In the health care industry, as in others in which the economic relationships of the different actors will shift depending upon the function they are performing, it is critical that the Court clarify that the *Copperweld* principle forbids subjecting intra-firm decisions to section 1 scrutiny. For example, governance of universities is significantly influenced by independent faculty members, who may decide to deny an appointment or tenure to an individual. It makes no sense to regard the faculty as "conspirators" with their university, even though the university itself may have to answer for discriminatory or other unlawful actions.[18] Only in an exceptional case might a faculty member stand in a competitive relationship with his or her own university, if for instance a dispute over rights to a patent or the like arose.

Some lower courts have identified exceptional cases in which a plaintiff alleges that the medical staff is not acting as the hospital's agent, but instead is pursuing its own

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[18] *Cf.* University of Pennsylvania v. E.E.O.C., 110 S.Ct. 577 (1990). In National Labor Relations Board v. Yeshiva University, 444 U.S. 672 (1980), the Court held that faculty members were functionally part of a university's management for purposes of collective bargaining under the labor laws. The Court rejected the NLRB's effort to treat "the professional interests of the faculty and the interests of the institution" as "distinct, separable entities," finding instead that "the faculty's professional interests—as applied to governance at a university like Yeshiva—cannot be separated from those of the institution." *Id.* at 688.

economic interest.[19] In such cases, two factors are almost always present: first, the decision-makers on the medical staff are direct competitors of the plaintiff physician, and second, the medical staff has the power directly to effect the exclusion.

Neither factor is present here. To the contrary, the defendant doctors involved in the peer review proceedings included an oncologist, an orthopaedic surgeon, an anesthesiologist, a proctologist and an internist. Dr. Bolt was a general and vascular surgeon. In today's world, no one sees an oncologist or a proctologist if he or she wants general or vascular surgery; the specialties of Dr. Bolt's reviewers simply do not compete with his own.

Furthermore, under Florida law and the bylaws of the petitioner hospital, the medical staff's role is to review membership applications and to make recommendations to the governing board of the hospital.[20] The fact that staff membership is ultimately at the Board's discretion is clearly reflected in the Board's bylaws:

> The Board of Commissioners shall *consider recommendations* of the Executive Committee of the Medical Staff and shall appoint to the Medical Staff physicians and dentists who meet the qualifi-

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[19] *See, e.g.*, St. Joseph's Hospital, Inc. v. Hospital Corp. of America, 795 F.2d 948 (11th Cir. 1986); Smith v. Underwood Memorial Hospital, 1987-1 Trade Cas. (CCH) ¶ 67,538 (D.N.J. 1987); Quinn v. Kent General Hosp., Inc., 617 F. Supp. 1226, 1242 (D. Del. 1985).

[20] Fla. Stat. § 395.0653(2) (1979). *See also* the Principles of Participation in the Federal Health Insurance Program for the Aged (Medicare), Florida Stat. § 395.065(1) (1979); 42 C.F.R. § 482.12(a)(2), (5) (1989).

> cations for membership *as determined by the Board.*[21]

Dr. Bolt did not allege in his complaint that the Board was pressured by the staff to depart in any way from their mission as trustees. He merely asserted in his brief to the court below that "the evidence indicates that the governing board defers to the recommendations of the Executive Committee with respect to medical staffing decisions." Brief for Appellant at 9. This assertion amounts to little more than the observation that the medical staff is comprised of physicians and the board of laymen. This is the desired result, where the Executive Committee makes its recommendations on medical grounds, and does not contradict the Board's power to ignore such a recommendation.

III. Conclusion

This case presents issues of great importance to the AHA's membership, and more broadly to all businesses that operate with a combination of independent agents and employees. The lower court's failure properly to analyze the economic relationship between a hospital and its medical staff, in the context of credentialing, led it to misapply this Court's decision in *Copperweld*. The Court in *Copperweld* emphasized that:

> a rule that punished coordinated conduct simply because a corporation delegated certain responsibilities to autonomous units might well discourage the corporation from creating divisions with their presumed benefits. This would serve no useful antitrust purpose but could well deprive consumers of the efficiencies that decentralized management may bring. *Copperweld*, 467 U.S. at 771.

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[21] Article VII of the Bylaws of Halifax Hospital Medical Center, *cited in* Petition for Writ of Certiorari, App. at 38a, n.3.

If the lower court's decision stands, hospitals will be deterred from consulting with their medical staff on credentialing decisions by the spectre of a never-ending series of antitrust suits. The AHA respectfully urges this Court to grant the petition for a writ of certiorari.

Respectfully submitted,

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